V. A. INTRODUCTION TO IMPROVING OUTCOMES

A key task in addressing discharge issues is the work to establish homelessness prevention policies and protocols to govern the expectations of public systems of care as they prepare to discharge their clients. There is inevitably a need to develop additional resources to bridge existing gaps from the back doors of institutions to the front door of residential systems, including transitional programs and permanent housing. There is a need to connect the day-to-day practices of public systems to new expectations, new tools, and new capacity in the community. Part V details some of the concrete approaches to making those connections in the daily operations of public systems and thus improve outcomes for homeless and at risk people.

Institutionalizing Policy in Purchasing and Procurement

Several examples of key resources are included. First, because the institutionalization of policy goals and expectations can be a key driver in changing the behavior of systems, purchase of service requirements for public contracting can be a critical resource. The George Washington University Center for Health Services Research and Policy (CHSRP) has prepared Optional Purchasing Specifications: Medicaid Managed Care for Individuals who are Homeless LINK to document V. B.]. This resource can assist providers and advocates in assessing their state Medicaid program and advocating for the needs of homeless clients in the Medicaid contracting process.

Since 1996, the Commonwealth of Massachusetts has operated a category of its Medicaid program under a federal waiver to give homeless non-disabled adults access to health care insurance. The Commonwealth's Division of Medical Assistance (DMA), with its for profit vendor, the Massachusetts Behavioral Health Partnership (MBHP), has evolved a set of contract performance standards for the DMA-MBHP contract, as well as standards for MBHP's network of private providers, including those who demonstrate a significant level of discharges to homelessness. Improving Behavioral Health Services and Discharge Planning for Homeless individuals [LINK to document V. C.] includes the standards, as well as instructive material directed to provider facilities.

An additional outgrowth of the Massachusetts state agency work group process described in Part IV was the creation and implementation of standard state procurement language for all state contract actions that might involve discharge to homelessness. The Commonwealth's Operational Services Division (OSD) issued Discharge Planning Specifications for Requests for Responses [LINK to document V. D.] as one of the final steps of the work group process. Providers can use this material to draft sample contract language that other states might adopt in procurement actions.

Bridging the Information Gap for New Resources

From the discharge planning conversations described in Part II, it was clear that font line staff also need one-stop up-to-date information to help identify appropriate program vacancies and supportive services. Too many relied on a handful of known programs, some of which might not be appropriate for their clients. Many used shelter contact lists as a way to ensure that clients could find a bed. Few really knew the environment of

emergency shelters or the limited resources many could offer. Many assumed the shelter system had a centralized intake with referral and placement information. MHSA developed Triple 8: The Road Home [LINK to document V. E.] as an interactive multimedia information tool. Triple 8 provides current vacancy information on next step transitional and permanent resources and can be accessed by FAX or on the Internet by case managers and discharge planners.

Building Appropriate Residential Capacity

Short stays in treatment or unmet treatment needs are common for homeless people emerging from public systems. Similarly, individuals who may have lost their housing while in care or no longer have community networks to rely on, need transitional residential placements upon discharge. A model for emerging ex-prisoners with treatment needs is described in the Introduction and relies in part on Emergency Shelter Grant funds. Other models have been well developed to meet the less acute needs of homeless people for stable recuperative settings. The Health Care for the Homeless Program has pioneered the "medical respite" model, described in Medical Respite Services for Homeless People: Practical Models [LINK to document V. F.]

Bridging Systems of Care

Many homeless people and those at risk on discharge have multiple needs for services and treatment. Interagency partnerships that are client focused require intent and maintenance to be beneficial. Increasing focus is being given to those individuals emerging from the corrections systems with mental health care needs. In For people with serious mental illnesses: Finding the Key to Successful Transition from Jail to the Community – An Explanation of Federal Medicaid and Disability Program Rules [LINK to document V. G.], the Bazelon Center for Mental Health Law demonstrates that appropriate discharge support for emerging prisoners must include knowledge of Medicaid and disability resources and a comprehensive view of the reentry needs of this population.